State of West Virginia
Credentialing Form

Please complete each section thoroughly.

Attach additional sheets where necessary.

(Indicate clearly the practitioner name and section on each attachment)

Type or print clearly in black ink.

Sign and date the application.

Practitioner's Name	**Date**
Social Security Number	**Date of Birth**
Credentialing Entity Name	

YOU MUST INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION

(Use this checklist as a guide)

- ☐ Copy of ALL current State License(s): For purposes of this application, State License shall include licensure from all 50 states, the District of Columbia, and U.S. Territories.
- ☐ Copy of current DEA Registration (if applicable)
- ☐ Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and Practitioner's name
- ☐ Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates
- ☐ Copy of certificate(s) or letter(s) certifying formal post-graduate training
- ☐ Copy of Curriculum Vitae/Resume (Include work history)
  (Not accepted as a substitute for completion of application.)
- ☐ Copy of ECFMG Certificate (if applicable)
- ☐ Copy of W-9 for verification of each tax identification number used (required for payers only)
- ☐ Copy of Visa or work permit (if not a U.S. citizen)
- ☐ Copies of CME/CEU session certificates (if required by Credentialing Entity)
- ☐ Signature requirements per each entity
- ☐ Professional Peer References (if required by Credentialing Entity)

CREDENTIALING ENTITIES MAY SUPPLEMENT THIS CHECKLIST OF REQUIRED ITEMS AS NEEDED TO MEET CREDENTIALING REQUIREMENTS.

State of West Virginia
Credentialing Form

Responses must be legible. Any response, which cannot be completed in the space provided, may be included on supplementary sheets of paper and attached. DO NOT LEAVE ANY FIELDS BLANK. If an item is not applicable, indicate N/A. Please note you will be held responsible for all information or omissions in this application, regardless of whether such statements were prepared by you, an employee, agent or representative. For time gaps greater than three (3) months provide information in Section 11. After completion of the application, you may photocopy and then submit with a signed attestation to each entity to which you wish to apply.

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

1. Applicant Information

Last Name (as shown on state license)	First Name	Middle Name	Maiden Name	Suffix (e.g., Jr., Sr., etc.)

Degree (e.g., MD, DO, DDS, DPM, PA-C, RN)	Gender	Birth Date	Birthplace
	Male ☐ Female ☐		

Other Name(s) Also Known By

Name(s)	Name:		Name:	
Date Name Used	From:	To:	From:	To:

Area(s) of Specialty (please be specific and list any primary focus)

Specialty:	Sub-specialty:

Citizenship

Are you a US Citizen?	☐ Yes ☐ No
Please provide the following information if you are not a US Citizen:	If no, what is your citizenship?
	If no, what is status of your Visa?
	If no, do you hold a permanent work permit?
	Type of Visa: / Expiration of Visa:

Social Security #	National Provider ID # (if available)	ECFMG # (if applicable, attach copy)	ECFMG Certificate Date

Current Home Address	City	State	Zip Code

Home Telephone	Is this # unlisted?	Home Fax
( ) -	☐ Yes ☐ No	( ) -

Language(s) Spoken (other than English)

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2. Office Practice Information

If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed. Indicate below whether the office is the primary or an additional site. (NOTE: Only one primary site should be designated.)

☐ Primary Office Site # 1	☐ Additional Office Site #

Group/Practice Name	
Type of Practice	☐ Individual ☐ Partnership ☐ Group ☐ Corporation ☐ Hospital Based ☐ Teaching or Research ☐ Other (specify):

Address (Building, Street, Suite #)	**City**

State	**Zip Code**	**County**

Telephone Number	**Fax Number**	**Answering Service/After-Hours Number**
( ) -	( ) -	( ) -

Alternate Telephone Number	**Cell Phone Number**	**Beeper/Pager Number**
( ) -	( ) -	( ) -

E-Mail Address	**Long Range Beeper Number**
	( ) -

Medicare Number	**UPIN Number**	**Medicaid Number**

Are you currently accepting new patients?	**Have you closed your practice to any plans or programs?**
☐ Yes ☐ By referral only ☐ No ☐ NA	☐ Yes ☐ No ☐ NA If Yes, please list:

Handicap Accessible?	**Public Transit Available?**
☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA

Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)	**If yes, list below what services are available**
☐ Yes ☐ No ☐ NA	

Office Manager's Name	**Nurse Manager's Name**	**Credentialing Contact**
☐ N/A	☐ N/A	Name ☐ N/A Phone #

Office Hours _____

☐ **Check if not applicable** ☐ **Check if practitioner is not available to see patient during hours indicated**

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Services Provided
(Please check below if these services are available)

☐ Lab Services	☐ On-Site	Reference Lab Name:	CLIA Number and Type of Certification:	
☐ Radiology Services	☐ EKG	☐ Sigmoidoscopy	☐ Audiology Services	☐ Treadmill
☐ Other (Please list):				
☐ List any special diagnostic or treatment procedures performed in your office:				

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Patient Population	
Do you limit the age of patients you treat?	**If yes, what ages do you treat?**
☐ Yes ☐ No	Minimum: Maximum:

Remittance/Billing Information (NOTE: Must match box 33 on HCFA/CMS 1500)			
Are all services payable to one practice or group name/address?	☐ Yes ☐ No		
Group/Practice Name (Check Payable To):			
Address (Building, Street, Suite #)	**City**	**State**	**Zip Code**

Billing Office Phone Number	**Billing Manager's Name**
( ) -	
Tax ID Number (must match W-9)	**Name affiliated with Tax ID Number (must match W-9)**

Business Interests	
Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?	☐ Yes ☐ No If yes, provide details on separate sheet.
Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?	☐ Yes ☐ No If yes, provide details on separate sheet.

Practice Classification

☐ Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services)

☐ Specialist Physician (Physicians other than primary care physicians in their designated clinical practice)

☐ Allied Health Professional (Licensed, certified, or registered non-physician Practitioners of direct patient care services)

☐ Dual Role (Serve as both a Primary Care Physician as well as a Specialist)

Directory Listing	
Should this office be listed in the directory?	**Should this office receive correspondence?**
☐ Yes ☐ No	☐ Yes ☐ No
Please indicate, in preference order, how you wish to be listed in the directory.	
Primary Specialty:	Secondary Specialty:

After-Hours Coverage	
Do you provide 24-hour coverage?	**Describe Coverage**
☐ Yes ☐ No ☐ NA	
Do you have an answering service/machine?	**Is your answering service/machine available at all times when you are not in the office?**
☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
List below other after-hours arrangements or special instructions to patients for after-hours care needs:	

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Back-up Coverage

(Please list the name, specialty, and phone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.)

Name	Specialty	Partner, Associate, Or Covering	Phone Number
			( ) -
			( ) -
			( ) -
			( ) -

Admitting Service

Do you admit patients to the hospital under your own service?	If no, to whom do you admit?
☐ Yes ☐ No ☐ NA	

Practitioner Extenders

Please check any of the following practitioner extender types and list individual names who you either employ or utilize for direct patient care.

☐ Physician's Assistant:	☐ Nurse Practitioner:
☐ Nurse Midwife:	☐ Other (specify):

Workers' Compensation Information

Do you accept Workers' Compensation Patients?	☐ Yes ☐ No
If yes, please provide the following information:	a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? ☐ Yes ☐ No b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. ☐ Yes ☐ No c. Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible. ☐ Yes ☐ No d. Staff are available and willing to provide compensation representatives information regarding a claimant's care. ☐ Yes ☐ No

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3. Medical/Professional Education:

(Attach copy of diploma. If international graduate, submit ECFMG Certificate.) If additional space is needed, please photocopy this page and attach. All time gaps greater than three (3) months must be accounted for in Section 11.

Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	**Phone # (if known)**	**Fax # (if known)**	**Graduation Date**
	( ) -	( ) -	
City	**State**	**Country**	**Zip Code**

Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	**Telephone # (if known)**	**Fax # (if known)**	**Graduation Date**
	( ) -	( ) -	
City	**State**	**Country**	**Zip Code**

4. Professional Training - Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. (Attach copies of all program certificates.) **All time gaps greater than three (3) months must be accounted for in Section 11.**

Training Institution		Program	
		☐ Internship ☐ Fellowship ☐ Other: ☐ Residency ☐ Preceptorship	
Street Address		**City**	
State	**Country**		**Zip Code**
Telephone # (if known)		**Fax # (if known)**	
( ) -		( ) -	
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**
	From: To:		☐ Yes ☐ No If no, explain:
Your Program Director's Name		**Current Program Director's Name (if known)**	

Training Institution		Program	
		☐ Internship ☐ Fellowship ☐ Other: ☐ Residency ☐ Preceptorship	
Street Address		**City**	
State	**Country**		**Zip Code**
Telephone # (if known)		**Fax # (if known)**	
( ) -		( ) -	
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**
	From: To:		☐ Yes ☐ No If no, explain:
Your Program Director's Name		**Current Program Director's Name (if known)**	

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Training Institution		Program		
		☐ Internship ☐ Residency	☐ Fellowship ☐ Preceptorship	☐ Other:
Street Address		**City**		
State	**Country**		**Zip Code**	
Telephone # (if known)		**Fax # (if known)**		
( ) -		( ) -		
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**	
			☐ Yes ☐ No If no, explain:	
Your Program Director's Name		**Current Program Director's Name (if known)**		

Training Institution		Program		
		☐ Internship ☐ Residency	☐ Fellowship ☐ Preceptorship	☐ Other:
Street Address		**City**		
State	**Country**		**Zip Code**	
Telephone # (if known)		**Fax # (if known)**		
( ) -		( ) -		
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**	
			☐ Yes ☐ No If no, explain:	
Your Program Director's Name		**Current Program Director's Name (if known)**		

5. State License(s): List **all** **current** and **past** professional licenses (Submit copy of current licenses)

State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	

Does the scope of your practice require the supervision of another practitioner?	☐ Yes ☐ No
If Yes, please list name of each supervising practitioner:	Practitioner Name:

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6. Certifications/Registrations

☐ **Check here if entire section is not applicable to applicant.**

Federal DEA Certificate
☐ **Not applicable**
(Submit copy of current DEA Certificate)

Certificate #	Expiration Date	Unlimited?
		☐ Yes ☐ No If no, explain:

State DEA or CDS Certificate(s)
☐ **Not applicable**
(Submit copy of current State Controlled Dangerous Substance Certificates, if applicable)

Certificate #	Expiration Date	Unlimited?
		☐ Yes ☐ No If no, explain:

Other Certificate(s)/Formal Training
(Please check below if currently certified. Submit copy(s))

- ☐ Basic Life Support (BLS)
- ☐ Advanced Cardiac Life Support (ACLS)
- ☐ Pediatric Advanced Life Support (PALS)
- ☐ Advanced Trauma Life Support (ATLS)
- ☐ Neonatal Advanced Life Support (NALS)
- ☐ Anesthesia Permit
- ☐ Health Care Practitioner (Core C)
- ☐ Neonatal Resuscitation Program (NRP)
- ☐ Therapeutics Classification Number (Optometrists only)
- ☐ Other (please list below or on a separate sheet and include descriptions):

7. Specialty Board Certification: Submit copies of board certifications and/or qualification confirmation letter.

☐ **Check here if entire section is not applicable to applicant.**

Are you board certified? ☐ **Yes** ☐ **No** **(If yes, list below)**

Certifying Board Name & Specialty	Initial Certification Date	Most Recent Recertification Date	Next Expiration Date

If not certified, are you qualified to sit for the examination?	☐ Yes ☐ No
If not certified, please indicate your status in the certifying process:	☐ Failed to pass specialty board examination • How many times have you taken the exam but failed to pass? _____ • Last date(s) exam was taken: _____ ☐ Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable: • Date(s) taken/retaken: _____ • Date scheduled, if applicable: _____ ☐ Not eligible to take specialty boards ☐ Not planning to take specialty boards ☐ Admissible with exam pending

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8. Professional Peer References

Please list three (3) professional peer references who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others, and who will provide specific written comments on these and other relevant matters upon request. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. These individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. At least one reference must be from the same specialty area, not formerly, currently or about to become associated with you in practice. At least one must be from an individual who has had organizational responsibility in a medical setting (e.g., Department Chair, Medical Director). If your training was completed within the past three (3) years, you may list your Program Director(s) as a professional reference. If you have been out of training for more than three (3) years, it is important to name individuals who are more currently familiar with your professional practice. The individuals should not be related to you by family or financial association.

Reference Name 1	Title		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Relationship: **(instructor, department chair, chief of staff, colleague, etc.)**			
Reference Name 2	Title		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Relationship: **(instructor, department chair, chief of staff, colleague, etc.)**			
Reference Name 3	**Title**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Relationship: **(instructor, department chair, chief of staff, colleague, etc.)**			

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9. Hospital/Health Care Entity Affiliations (list current affiliation first)

☐ **Check here if entire section is not applicable to applicant.**

List **ALL** health care facilities at which you currently have, or have had, privileges. **Explain gaps greater than three (3) months in Section 11.**

Name of Current Primary Hospital Affiliation	**Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

Name of Affiliation/Hospital/Healthcare Entity	**Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

Name of Affiliation/Hospital/Healthcare Entity	**Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		

Staff Status	# Admits/Month	Percent of time spent at facility

Restricted?	Dates of Affiliation (Mo/Yr)
☐ Yes ☐ No If yes, explain:	From: To:

Reason for leaving, if applicable

9. Additional Affiliations:

(Photocopy this page for additional affiliations)

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)

Street Address	City	State	Zip

Telephone Number	Fax Number
( ) -	( ) -

Department/Service	Department Chair's Name

Staff Status	# Admits/Month	Percent of time spent at facility

Restricted?	Dates of Affiliation (Mo/Yr)
☐ Yes ☐ No If yes, explain:	From: To:

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)

Street Address	City	State	Zip

Telephone Number	Fax Number
( ) -	( ) -

Department/Service	Department Chair's Name

Staff Status	# Admits/Month	Percent of time spent at facility

Restricted?	Dates of Affiliation (Mo/Yr)
☐ Yes ☐ No If yes, explain:	From: To:

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)

Street Address	City	State	Zip

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Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

10. Work History/Experience:

List in chronological order (beginning with current) all current and previous professional work history including Military Service. You must explain gaps greater than three (3) months in Section 11. (If additional space is needed, please photocopy this page and attach.)

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		
From: To:			
Reason for leaving, if applicable			

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		
From: To:			
Reason for leaving, if applicable			

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		

From: To:	
Reason for leaving, if applicable	

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		
From: To:			
Reason for leaving, if applicable			

11. Time Gaps

Provide information for all time frames of three (3) months or more that are not covered in Medical/Professional Education, Professional Training, Hospital/Health Care Entity Affiliations, or Work History/Experience sections (such as extended travel, maternity leave, relocation, etc.).

☐ **Check here if entire section is not applicable to applicant.**

Section	Dates	Explanation
Medical/Professional Education	From: To:	
	From: To:	
	From: To:	
Professional Training	From: To:	
	From: To:	
	From: To:	
Hospital/Health Care Entity Affiliations	From: To:	
	From: To:	
	From: To:	
Work History/Experience	From: To:	
	From: To:	
	From: To:	

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12. Continuing Education Requirements

☐ **Check here if entire section is not applicable to applicant.**

A. Have you completed the continuing education hours as required by your State Licensing Board during the past two (2) years OR the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing?	☐ Yes	☐ No

B. Attach certificates as noted on Page 1 for the CME/CEU sessions you have completed in last two (2) years (if required by Credentialing Entity).

13. Professional Associations/Organizations

List the associations/organizations related to your profession in which you are a member. Please include dates of affiliations. Include faculty appointments.

☐ **Check here if not applicable**

Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:

14. Professional Liability Insurance Coverage:

Submit a copy of your current professional liability insurance coverage face sheet showing coverage in your practice specialty. Please list current and previous insurance carriers for the last ten (10) years in chronological order beginning with most current. (If additional space is needed, please photocopy this page and attach.)

Current Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

Second Current Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

Previous Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

Previous Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

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15. Professional Liability Insurance Coverage Disclosure:

If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter on the attached Professional Liability Information Addendum. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.

A. Has your professional liability insurance coverage ever been terminated by action of the insurance company?	☐ No	☐ Yes
B. Have you ever been denied professional liability insurance coverage?	☐ No	☐ Yes
C. Has any (current or previous) professional liability insurance carrier excluded any specific procedures or specific area of practice (e.g., obstetrics, surgery, etc.) from your coverage?	☐ No	☐ Yes
D. During the time of your professional practice, have you had any professional liability claims, suits, settlements, or judgments filed against you or are any currently pending?	☐ No	☐ Yes
E. Have any restrictions ever been placed on your professional liability insurance coverage?	☐ No	☐ Yes
F. Have you ever practiced without professional liability coverage?	☐ No	☐ Yes
G. Are there any incidents for which you have been contacted by an attorney regarding potential professional liability (e.g., settlement requests, writ of summons, etc.)?	☐ No	☐ Yes

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

Professional Liability Information Addendum

(Photocopy this form for each case/action)

Please supply the following and sign and date this form:

- **Information for each professional liability action you have had taken against you, including those pending.**
- **Information for each settlement, or decision for the plaintiff that has ever occurred on your behalf.**
- **Practitioner Signature and Date**

All information is held in strict confidence and used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved. In addition to completion of this form, practitioner may also submit any additional supporting documentation.

☐ **Check here if entire section is not applicable to applicant (and sign below even if no suits or settlements).**
☐ **Check here if no professional liability actions/claims filed (and sign below even if no suits or settlements).**

1. Case Number	**2. Carrier Name**
3. Name of Plaintiff	**4. Date of Incident**
5. Date Filed	**6. Date Closed**
7. What was/is your status in the case?	**8. What is the status of the case?**
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	☐ Dropped ☐ Pending ☐ Settled Out of Court ☐ Found for Defendant ☐ Dismissed Without Payment ☐ Found for Plaintiff ☐ Under Appeal
9. Amount of Any Settlement or Award?	**10. Date of any Settlement or Award**

Please explain the following in detail. (If an item does not apply please check "N/A")

11. What was the alleged harm to the patient?		☐ N/A
12. What were you alleged to have done incorrectly or failed to do?		☐ N/A
13. Describe the patient's illness and related effects of the alleged harm.		☐ N/A
14. Describe any other details you believe are pertinent to the case.		☐ N/A
15. Identify any other parties named in the suit.		☐ N/A

Practitioner Signature (REQUIRED)	**Date (REQUIRED)**

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

16. Practice Disclosure Information

If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.

A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	☐ No	☐ Yes	
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	☐ No	☐ Yes	
C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	☐ No	☐ Yes	
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	☐ No	☐ Yes	☐ NA
E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending?	☐ No	☐ Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	☐ No	☐ Yes	☐ NA
G. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status?	☐ No	☐ Yes	☐ NA
H. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care entity?	☐ No	☐ Yes	
I. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence?	☐ No	☐ Yes	
J. Have your ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care entity while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care entity?	☐ No	☐ Yes	
K. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
L. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
M. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care entity, or branch of the armed forces?	☐ No	☐ Yes	
N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?	☐ No	☐ Yes	

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	☐ No	☐ Yes	
P. Have you had any charges of unprofessional conduct brought against you?	☐ No	☐ Yes	
Q. Have you had any charges of fraud brought against you?	☐ No	☐ Yes	
R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.	☐ No	☐ Yes	

Health Status

Note: Your application will be processed in the usual manner regardless of how you answer questions A and B. If you have answered "No" to question A or B, please explain completely on a separate sheet. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.

A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?	☐ Yes	☐ No
B. Are you able to perform these functions without significant risk of injury to yourself or others?	☐ Yes	☐ No
C. Do you illegally use drugs?	☐ Yes	☐ No
Have you used illegal drugs within the last two years?	☐ Yes	☐ No
D. Do you currently take any medications that may affect your ability to perform the clinical privileges or scope of practice requested competently and safely?	☐ Yes	☐ No

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

Health Care Entity:	

WEST VIRGINIA PRACTITIONER
ATTESTATION/AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this attestation/authorization and release of information form in conjunction with the West Virginia Credentialing Form (WVCF) and/or the West Virginia Practitioner Attestation/Authorization, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Health Care Entity indicated on the WVCF for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.

2. I further understand and acknowledge that the Health Care Entity or designated Agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Health Care Entity as part of the verification and credentialing process.

3. I authorize all individuals, institutions, and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Health Care Entity(ies), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the requested clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the WVCF Attestation/Authorization and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.

6. I agree to exhaust all available procedures and remedies as outlined by in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Health Care Entity(ies) where I have membership and/or clinical privileges/participation.

7. I understand that completion and submission of the WVCF Attestation/Authorization and Release of Information does not automatically grant me membership or clinical privileges/participating status with the Health Care Entity(ies) indicated on the WVCF or Attestation/Authorization.

8. I further acknowledge that I have read and understand the foregoing Attestation/Authorization and Release of Information. A photocopy of this Attestation/Authorization and Release of Information shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation/authorization.

9. I release from liability any and all individuals and organizations who provide information to the credentialing entity in good faith and without malice concerning my professional qualifications and competence, and the credentialing entity, from liability for their acts performed and statements made relating but not limited to verifying, evaluating and acting upon my credentials and qualifications.

Print Name Here: _____

Signature: _____ Date: _____

NOTE: Through above signature, I hereby affirm that contents are current, accurate, and complete as of the signature date.

Modification to the wording or format of the WVCF/Attestation/Authorization and Release of Information may invalidate an application.

Credentialing Entity may supplement additional Attestation/Authorization/Release of Information through an additional release document as required by the entity.

The Entities will treat this application and any information secured in connection therewith in strict confidence in accordance with the Entities' policies and/or Medical Staff Bylaws and preserve with all reasonable safeguards the privacy of the Applicant.

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

I, the undersigned, authorize my CURRENT professional liability insurance carrier,

_____

(Enter Current Professional Liability Insurance Carrier Name)

_____

(Enter Street Address) (City) (State & Zip)

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage, and any limitations in coverage, to _____ .

(Entity Specific)

_____ is to hereinafter be

(Entity Specific)

a Certificate Holder and is to be notified of the amount of my coverage and any future changes in my insurance status, to include all information regarding claims history (but not necessarily limited to judgments entered, claims settled, cases and lawsuits pending), and any restriction regarding specific privileges which may be excluded from coverage.

I will notify _____ of any

(Entity Specific)

changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

_____ _____

Practitioner's Signature Date

_____

Printed Name

_____

Policy Number

(Instructions: Please complete, sign, date and return to entity named above with your initial application.)

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

DAVIS VISION, INC.

PARTICIPATING PROVIDER AGREEMENT

This **PARTICIPATING PROVIDER AGREEMENT** is entered into as of the _____ day of _____, 20__ ("Effective Date") by and between **DAVIS VISION, INC.**, having its principal place of business located at 159 Express Street, Plainview, New York 11803 ("**DAVIS"**), and _____

_____

[Insert PROVIDER's full legal entity name]

having its, his or her principal place of business located at _____

_____("**PROVIDER"**).

[Insert PROVIDER's complete address]

RECITALS

WHEREAS, **DAVIS** has or intends to enter into agreements with health maintenance organizations and other purchasers of health care services ("**Plan**(s)") to provide or arrange for the provision of health care services to persons enrolled as Participants of such Plans (the "**Contracts"**); and

WHEREAS, **DAVIS** and **PROVIDER** desire to enter into a contract whereby **PROVIDER** agrees to provide certain health care services on behalf of **DAVIS** to Participants of Plans under Contract with **DAVIS**.*****

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, and intending to be bound hereby, the parties agree as follows:

I

DEFINITIONS

.1 "**Clean Claim**" means a claim for payment for services which contains the following information: (a) a valid authorization number, referencing member, and Participant information; (b) a valid **DAVIS** assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an indication as to whether or not dilation was performed; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pended or denied until all information is received from the **PROVIDER** and/or member.

.2 "**Contracts"** means the agreements between **DAVIS** and Plans to provide or arrange for the provision of health care services to persons enrolled as Participants of such Plans.

.3 "**Copayment" or "Deductible"** means those charges for health care services, which shall be collected directly by **PROVIDER** from Participant as payment, in addition to the fees paid to **PROVIDER** by **DAVIS**, in accordance with the Participant's benefit plan.

.4 "**Covered Services"** means a complete and routine eye examination including, but not limited to, visual acuities, internal and external examination, including dilation where professionally indicated, refraction, binocular function testing, tonometry, neurological integrity, biomicroscopy, keratometry, diagnosis and treatment plan and, when authorized by state law and covered by a Plan, medical eye care, diagnosis, treatment and eye care management services, and ordering and dispensing plan eyeglasses from the central **DAVIS** laboratory.

.5 "**Medically Appropriate"** means services or treatment which a Participant requires as determined by one or more Participating Provider(s), in accordance with accepted professional practices and standards prevailing at the time of treatment and adopted by **DAVIS**.

.6 **"Non-Covered Services"** means those health care services which are not Covered Services.

.7 "**Participant"** means a person who is enrolled in a Plan (including enrolled dependents) and is entitled to receive Covered Services.

.8 "**Participating Provider"** means a licensed health facility which, or a licensed health professional who, has entered into an agreement with a Plan or with **DAVIS** to provide Covered Services to Participants.

.9 "**Plans"** means health maintenance organizations and other purchasers of health care services.

.10 "**Provider Manual"** means the **DAVIS** Vision Care Plan Provider Manual, as amended by **DAVIS** from time to time.

II

SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **Services: PROVIDER** shall provide all Medically Appropriate Covered Services to Participants within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Participant to ensure that it is cost-effective and Medically Appropriate.

.2 **Frame Collection:** As a bailment, **PROVIDER** shall maintain the selection of Plan approved frames, **if applicable**, in accordance with the Provider Manual and as set forth herein:

(a) **PROVIDER** agrees that the frame collection will be shown to all Participants receiving eyeglasses under the Plan.

(b) **PROVIDER** agrees that the frame collection shall be openly displayed in an area accessible to all Participants.

(c) **PROVIDER** shall maintain the frame collection in the exact condition in which it was delivered less any normal deterioration.

(d) **PROVIDER** shall not permanently remove any frames from the display. **PROVIDER** shall not remove any advertising materials from the display.

(e) The cost of the frame collection and display is assumed by **DAVIS** and remains the property of **DAVIS**. **DAVIS** retains the right to take possession of the frame collection when **PROVIDER** ceases to participate with the Plan and, with reasonable notice, at any other time. **PROVIDER** assumes full responsibility for the cost of any missing frames and will be required to reimburse **DAVIS** for missing and unaccounted for frames.

(f) Upon reasonable notice, and at any time, **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection.

(g) Should the display and/or frame(s) contained in the collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume full cost of the display and/or frame collection and will be required to reimburse **DAVIS** its fair market value.

.3 **Treatment Records: PROVIDER** shall (1) establish and maintain a treatment record consistent, in form and content, with generally accepted standards and the requirements of **DAVIS** and Plans; and (2) promptly provide **DAVIS** and Plans with copies of treatment records when requested; and (3) shall keep treatment records confidential.

.4 **Nondiscrimination**: Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Participant(s)s covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** agrees not to differentiate or discriminate in the treatment of persons covered under the Plans as to the quality of service delivered because of race, sex, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status or method of payment; and to promote, observe and protect the rights of Participant(s)s covered under the Plans.

.5 **Open Clinical Dialogue**: Nothing contained herein shall preclude **PROVIDER** from engaging in open clinical dialogue with Participants, including but not limited to the discussion of all possible and/or applicable treatments, whether such treatments are Covered Services under the applicable **DAVIS** plan designs.

III

COMPENSATION

.1 **Compensation: DAVIS** shall pay **PROVIDER** the compensation amounts communicated to **PROVIDER** by **DAVIS** from time to time, and hereby incorporated by reference, as full compensation for the Covered Services provided by **PROVIDER** to Participants under an applicable Plan pursuant to this Agreement. **DAVIS** shall not provide **PROVIDER** with any financial incentive to withhold Covered Services, which are Medically Appropriate. Further, the parties hereto agree to comply with and to be bound by, to the same extent as if the sections were restated in their entirety herein, the provisions of 42 CFR §417.479 and 42 CFR §434.70, as amended by the final rule effective January 1, 1997, and as promulgated by the Health Care Financing Administration, Department of Health and Human Services. In part, these sections govern physician incentive plans operated by Federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program. As applicable and pursuant to 42 CFR §417.479 and 42 CFR §434.70, no specific payment will be made directly or indirectly, under Plans hereunder, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a Participant.

.2 **Payment of Compensation:** Payment shall be made within thirty (30) days of receipt of a Clean Claim by **DAVIS, or in accordance with the applicable state's prompt pay statute, whichever is less**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Participant, less any Copayment and Deductible collected or to be collected from the Participant. For all Covered Services rendered by **PROVIDER** to a Participant hereunder, **PROVIDER** shall, within sixty (60) days following the provision of Covered Services, submit to **DAVIS** an invoice. (Such invoice may be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**). Failure of **PROVIDER** to submit said invoice within sixty (60) days of service delivery will, at **DAVIS'** option, result in nonpayment by payor to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, erroneous claim payments or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

.3 **Participant Billing/Hold Harmless:** Except as provided in Section III.4 below, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Participants and shall at no time seek compensation from Participants for Covered Services even if **DAVIS**, for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Participant shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Participant's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, shall survive termination of this Agreement regardless of the reason for termination, shall be construed to be for the benefit of the Participant and, may not be changed without the approval of appropriate regulatory authorities.

.4 **Participant Responsibility: PROVIDER** shall bill and collect all Copayments and Deductibles specifically permitted in a Participant's benefit plan from the Participant. **PROVIDER** shall further bill and collect all charges from a Participant for those non-Covered Services provided to a Participant. To the extent permitted by law, **PROVIDER** shall provide a courtesy discount of twenty percent (20%) off **PROVIDER'**s usual and customary fees to Participants for the purchase of materials not covered by a Plan.

.5 **Plan Hold Harmless Provisions: PROVIDER** agrees that he/she shall look only to **DAVIS** for compensation for Covered Services as set forth above and shall hold harmless each Plan from any obligation to compensate **PROVIDER** for Covered Services.

IV

OBLIGATIONS OF PROVIDER

.1 **Hours: PROVIDER** agrees to be available to provide Covered Services for Medically Appropriate emergency care and shall be accessible twenty- four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year through an answering service or answering machine which provides a pager number. Services not requiring emergency care shall be provided on a timely basis.

.2 **COB Obligation of PROVIDER: PROVIDER** shall cooperate with **DAVIS** with respect to Coordination of Benefits (COB) and will bill and collect from other payer(s) such charges for which the other payer(s) are responsible. **PROVIDER** shall report all payments and collections received and attach all Explanations of Benefits (EOBs) in accordance with this Section IV.2 to **DAVIS** when billing is submitted for payment.

.3 **Malpractice Insurance:** Unless otherwise agreed upon in a writing by and between the parties hereto, **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire term of this Agreement, maintain a policy of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER'**s agents, servants or employees, and **PROVIDER** shall provide proof of such insurance to **DAVIS** if so requested.

.4 **Performance: PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Participant(s). **PROVIDER** shall use his/her/its best efforts to ensure that health care services provided under this Agreement are of a quality that is consistent with accepted professional practices. **PROVIDER** agrees to abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of health care services.

.5 **Compliance with Law and Ethical Standards:** During the term of this Agreement, **PROVIDER** and **DAVIS** shall at all times comply with all applicable federal, state or municipal statutes or ordinances, all applicable rules and regulations, and the ethical standards of the appropriate professional society. If at any time during the term of this Agreement, **PROVIDER'**s license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall timely notify **DAVIS,** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect. **PROVIDER** agrees to cooperate with **DAVIS** so that **DAVIS** may meet any requirements imposed on **DAVIS** by state and federal law, as amended, and all regulations issued pursuant thereto. As may be required by law, **PROVIDER** agrees to maintain such records and provide such information to **DAVIS,** and to contracting Plans, and applicable state and federal regulatory agencies for compliance. **PROVIDER** agrees to retain such books and records for a term of at least six (6) years from and after the provision of Covered Services and in the case of a minor who receives services from **PROVIDER**, for a minimum of six (6) years from the time such minor attains the age of majority. **PROVIDER**'s obligations contained in Section IV.5 herein shall survive termination of this Agreement.

.6 **PROVIDER Roster: PROVIDER** agrees that **DAVIS** and each Plan which contracts with **DAVIS** may use **PROVIDER'**s name, address, phone number, type of practice, and willingness to accept new patients in the **DAVIS** or Plan roster of Provider participants. The roster may be inspected by and is intended to be used by prospective patients and others.

.7 **Compliance with DAVIS Rules: PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS**, including, without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes Davis may, from time to time, amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

.8 **Cooperation with Plan Medical Directors: PROVIDER** understands that contracting Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Participants and that contracting Plans in certain instances will have the right to oversee and review the quality of care administered to Participants. **PROVIDER** agrees to cooperate with contracting Plan medical directors in the medical directors' review of the quality of care administered to Participants.

.9 **Notice of Non-Compliance and Malpractice Actions: PROVIDER** shall notify **DAVIS** immediately, in writing, should he/she/it be in violation of any portion of this Article IV. Additionally, **PROVIDER** shall advise **DAVIS** of each malpractice claim filed against **PROVIDER** and each settlement or other disposition of a malpractice claim entered into by **PROVIDER** within fifteen (15) days following said filing, settlement or other disposition.

.10 **Consent to Release Information:** Upon request by DAVIS, **PROVIDER** shall provide **DAVIS** with authorizations, consents or releases as **DAVIS** may request in connection with any inquiry by **DAVIS** of any hospital, educational institution, governmental or private agency or association (including without limitation the National Practitioner Data Bank) or any other entity or individual relative to **PROVIDER'**s professional qualifications, **PROVIDER'**s mental or physical fitness, or the quality of care rendered by **PROVIDER**.

.11 **Credentialing: PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**.

.12 **Verification of Eligibility: PROVIDER** shall verify eligibility of Participant(s) by calling the appropriate toll-free (800/888) number supplied by **DAVIS** or by receiving from Participant(s) a valid pre-certified voucher.

.13 **Office Visits: PROVIDER** shall cooperate with all office visits made by **DAVIS**, any external review organization or regulatory agency.

V

TERM OF THE AGREEMENT

.1 **Term:** This Agreement shall become effective on the date first written above and shall thereafter be effective for an initial term of twelve (12**)** months.

.2 **Renewals**: This Agreement shall be automatically renewed for successive twelve (12) month periods on the same terms and conditions contained herein, unless sooner terminated pursuant to the terms of this Agreement.

VI

TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause:** After the initial twelve (12) month term this Agreement may be terminated by either party, without cause, upon ninety (90) days prior written notice. If **DAVIS** elects to terminate this Agreement other than at the end of a term hereof, or for a reason other than those set forth in Section VI.2 hereof, **PROVIDER** may request a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of receipt of **PROVIDER**'s request.

.2 **Termination With Cause: DAVIS** may terminate this Agreement immediately for cause or may suspend continued participation as set forth below. "Cause" shall mean:

(a) a suspension, revocation or conditioning of **PROVIDER'**s license to operate or to practice his/her/its profession;

(b) suspension, or a history of suspension, of **PROVIDER** from Medicare or Medicaid;

(c) conduct by **PROVIDER** which endangers the health, safety or welfare of Participants;

(d) any other material breach of any obligation of **PROVIDER** under the terms of this Agreement;

(e) conviction of a felony;

(f) loss or suspension of a Drug Enforcement Administration (DEA) identification number;

(g) voluntary surrender of **PROVIDER**'s license to practice in any state in which the **PROVIDER** serves as a **DAVIS** provider while an investigation into the **PROVIDER**'s competency to practice is taking place by the state's licensing authority;

(h) the bankruptcy of **PROVIDER.**

"Cause" for the purposes of suspension shall mean:

(a) a failure by **PROVIDER** to maintain malpractice insurance coverage as provided in Section IV.3 hereof;

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section IV.5 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS'** rules and regulations as required in Section IV.7 hereof;

(d) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section VIII.1 hereof;

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section IX.12 hereof;

Provided, however, that **PROVIDER** shall not be penalized nor shall this Agreement be terminated or suspended because **PROVIDER** acts as an advocate for a Participant in seeking appropriate Covered Services, or files a complaint or an appeal.

.3 **Responsibility for Participants at Termination:** In the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section IV.5 hereof), **PROVIDER** shall continue to provide Covered Services to a Participant who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement until the Covered Services being rendered to the Participant by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a Participant), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Participant pursuant to this Section VI.3 (prior to and following the effective termination date of this Agreement) at the rates contemplated in this Agreement for Covered Services.

.4 **PROVIDER Rights Upon Termination:** Except as otherwise required by law, **PROVIDER** agrees that, subject to the appeal process set forth in the Provider Manual, any **DAVIS** decision to terminate this Agreement pursuant to this Article VI shall be final.

.5 **Return of Materials and Payments of Amounts Due:** On termination of this Agreement, **PROVIDER** shall return to **DAVIS** any Plan or **DAVIS** materials including, but not limited to, frame samples, displays, manuals and contact lens materials, and shall pay **DAVIS** any monies due with respect to claims or for materials and supplies. **DAVIS** may setoff any monies due from **DAVIS** to **PROVIDER** if **PROVIDER** owes any monies to **DAVIS**. **DAVIS** may reclaim frame samples at any time during the term of this Agreement.

.6 **Provider Notification to Participants upon Termination:** Should **PROVIDER** terminate this Agreement pursuant to Section VI.1 above, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Participant(s) under this Agreement, **PROVIDER** agrees to notify said Participant(s) of the termination prior to its effective date.

VII

DOCUMENTATION AND AMENDMENT

.1 **Documentation: DAVIS** shall provide **PROVIDER** with a copy of any document required by a contracting Plan which has been approved by **DAVIS** and which requires **PROVIDER's** signature. If **PROVIDER** does not execute and return said document within fifteen (15) calendar days of document receipt, **DAVIS** may execute said document as agent of **PROVIDER** and said document shall be deemed to be executed by **PROVIDER**.

.2 **Amendment:** This Agreement may be amended by **DAVIS** with thirty (30) days advance written notice to **PROVIDER**.

VIII

UTILIZATION REVIEW, QUALITY MANAGEMENT AND GRIEVANCE PROCEDURES

.1 **Utilization Review and Quality Management Procedures:** Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Participants. Such programs will be established by **DAVIS**, in its sole and absolute discretion, and will be in addition to any utilization review and quality management programs required by a Plan. **PROVIDER** shall comply with and, subject to **PROVIDER's** rights of appeal, shall be bound by all such utilization review and quality management programs. If requested, **PROVIDER** may serve on the utilization review and/or quality management committee of such programs in accordance with the procedures established by **DAVIS** and Plans. Failure to comply with the requirements of this Section VIII.1 may be deemed by **DAVIS** to be a material breach of this Agreement and may, at **DAVIS'** option, be grounds for immediate termination by **DAVIS** of this Agreement. **PROVIDER** agrees that decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment hereunder for those Covered Services provided to a Participant which are determined to be not Medically Appropriate or of poor quality or for which **PROVIDER** failed to receive a prior authorization to treat a Participant.

.2 **Grievance Procedure:** A grievance procedure shall be established for the processing of any Participant or **PROVIDER** complaint regarding Covered Services. Such procedure will be established by **DAVIS** and contracting Plans, in their sole and absolute discretion. **PROVIDER** shall comply with and, subject to **PROVIDER's** rights of appeal, be bound by such grievance procedure.

IX

GENERAL PROVISIONS

.1 **Notices:** Should either party be required or permitted to give notice to the other party hereunder, such notice shall be given in writing and shall be delivered personally or by first class mail. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of three (3) days after mailing. Notices shall be delivered or mailed to the addresses appearing in the introductory paragraph on the first page of this Agreement. Either party hereunder may change its address by providing written notice in accordance with this Section IX.1.

.2 **Entire Agreement of the Parties:** This Agreement supersedes any and all agreements, either written or oral, between the parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the parties with respect to the rendering of Covered Services. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, have been made by either party, or anyone acting on behalf of either party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing signed by the party to be charged.

.3 **Severability:** Should any provision of this Agreement be held to be invalid, void or unenforceable by a court of competent jurisdiction or by applicable state or federal law and their implementing regulations, the remaining provisions of this Agreement will nevertheless continue in full force and effect.

.4 **Arbitration:** Any controversy or claim arising out of or relating to this Agreement, or to the breach thereof, will be settled by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur within the State of New York, unless the parties mutually agree to have such proceedings in some other locale. In any such proceeding, the arbitrator(s) may award attorneys' fees and costs to the prevailing party.

.5 **Governing Law:** This Agreement shall be governed by and construed in accordance with the laws of the state in which **PROVIDER** maintains his, her, or its principal office or, if a dispute concerns a particular Participant, in the state in which **PROVIDER** rendered services to that Participant.

.6 **Assignment:** This Agreement shall be binding upon, and shall inure to the benefit of the parties to it and their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, **PROVIDER** may not assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of **DAVIS**.

.7 **Independent Contractor:** At all times relevant to and pursuant to the terms and conditions of this Agreement, **PROVIDER** is and shall be construed to be an independent contractor practicing **PROVIDER'**s profession and shall not be deemed to be or construed to be an agent, servant or employee of **DAVIS**.

.8 **Confidentiality:** The terms of this Agreement and in particular the provisions regarding compensation are confidential and shall not be disclosed except as and only to the extent necessary to the performance of this Agreement or as required by law.

.9 **Waiver:** The waiver of any provision or of the breach of any provision of this Agreement must be set forth specifically in writing and signed by the waiving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

.10 **Headings:** The subject headings of the articles and sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of its provisions.

.11 **Third Party Beneficiaries:**

(a) Plans. Plans are intended to be third-party beneficiaries of this Agreement. Plans shall be deemed, by virtue of this Agreement to have privity of contract with **PROVIDER** and may enforce any of the terms hereof.

(b) Other Persons. Other than the Plans and the parties hereto and their respective successors or assigns, nothing in this Agreement whether express or implied, or by reason of any term, covenant, or condition hereof, is intended to or shall be construed to confer upon any person, firm, or corporation, any remedy or any claim as third party beneficiaries or otherwise; and all of the terms, covenants, and conditions hereof shall be for the sole and exclusive benefit of the parties hereto and their successors and assigns.

.12 **Non-Solicitation of Participants:** During the term of this Agreement and for a period of two (2) years after the effective date of termination of this Agreement, **PROVIDER** shall not directly or indirectly engage in the practice of solicitation of Participants, Plans or any employer of said Participants without **DAVIS'** prior written consent. For purposes of this Agreement, a solicitation shall mean any action by **PROVIDER** which **DAVIS** may reasonably interpret to be designed to persuade or encourage (i) a Participant or Plan to discontinue his/her/its relationship with **DAVIS** or (ii) a Participant or an employer of any Participant to disenroll from a Plan contracting with **DAVIS**. A breach of this Section IX.12 shall be grounds for immediate termination of this Agreement.

.13 **Use of Name: PROVIDER** shall not use **DAVIS'** or any Plan's name or logo without the written authorization of **DAVIS** or such Plan.

.14 **Proprietary Information:** **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Participant, including but not limited to, the Participant's name, address and telephone number ("Participant Information"), and all other "**DAVIS** trade secret information". For purposes of this Agreement, "**DAVIS** trade secret information" shall include but shall not be limited to: (i) all **DAVIS** Plan agreements and the information contained therein regarding **DAVIS**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or any Plan and **DAVIS**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS**. **PROVIDER** shall not disclose or use any Participant Information or **DAVIS** trade secret information for his/her/its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement; provided, however, that **PROVIDER** may use the name, address and telephone number, and/or medical information of a Participant if Medically Appropriate for the proper treatment of such Participant or upon the express prior written permission of **DAVIS**, the Plan in which the Participant is enrolled, and the Participant.

IN WITNESS WHEREOF, the parties have set their hand hereto and this Agreement is effective as of the Effective Date first written above.

DAVIS VISION, INC.:

By: _____
Name: _____
Title: _____
Date: _____

PROVIDER:

By: _____
Print Name: _____
Print Title: _____
Date: _____
(PROVIDER MUST sign, print name, print title, and date)

***** Submission of a completed Vision Care Provider Application and/or submission of a signed Participating Provider Agreement does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of the Vision Care Provider Application and, on the execution by practitioner of the Participating Provider Agreement and, on the receipt by practitioner of the forms, manual and samples required for participation. **DAVIS** reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a **PROVIDER's** acceptance by **DAVIS,** should additional practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Participants of Plans under Contract with **DAVIS**, such additional practitioner(s) shall be subject to and bound by each and every term and condition set forth in this Agreement to the same extent as the original signatories to this Agreement.